Confidential medical form

We ask for information regarding your general health to help us treat you safely. Please complete both sides of this form and sign. All information will be kept strictly confidential.

Full name .... DOB ....

Address ....

....Daytime tel ....

Mobile .... Email ....

Sex (please tick) male ☐ female ☐ Occupation ....

Doctor's name, address and telephone ....

....

Are you under medical care or taking any prescribed or self-prescribed medication? (in particular Warfarin)

Yes ☐ No ☐ If yes, what medication are you on? (please use extra sheet if necessary) ....

....

Have you had any of the following? (please tick all that apply)

- ☐ Rheumatic fever
- ☐ Congenital heart condition/pacemaker
- ☐ Heart condition/angina
- ☐ High or low blood pressure
- ☐ Stroke
- ☐ Diabetes
- ☐ Epilepsy, fits, fainting attacks
- ☐ Arthritis or joint replacement
- ☐ Jaundice or liver disease
- ☐ Infectious diseases incl. HIV & hepatitis
- ☐ Bronchitis, asthma, chest conditions
- ☐ Prolonged bleeding/bruising problems
- ☐ A medical warning card
- ☐ Allergies (please specify) ....

Have you had any ill effects from any of the following? (please tick all that apply)

☐ Antibiotics, penicillin, aspirin ☐ Local or general anaesthetic ☐ Dental treatment

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- ☐ Do you think you may be pregnant?
- ☐ Have you had a baby in the last year?
- ☐ Have you had a blood transfusion?
- ☐ Do you have problems lying flat?
- ☐ Do you suffer from cold sores?
- ☐ Have you ever had a close relative with CJD?
- ☐ Have you ever had an operation?

(please specify) ....

Do you smoke?	Yes	☐	No	☐	If yes, how many a day?	....
Do you drink alcohol?	Yes	☐	No	☐	If yes, how many units a week?	....
Do you drink fizzy drinks?	Yes	☐	No	☐	If yes, how many drinks a week?	....
Do you drink fruit tea?	Yes	☐	No	☐	If yes, how many cups a week?	....
Do you drink smoothies?	Yes	☐	No	☐	If yes, how many a week?	....

Dental & hygiene information

Have you been seeing a dentist regularly? (please tick) Yes ☐ No ☐

If yes, how often? ....

Are you a nervous patient? (Please circle one of the boxes below).

1 equals not nervous and 5 equals very nervous. 1 2 3 4 5

When was your last hygiene/cleaning appointment? ....

Question	Yes	No
Do you sometimes suffer from bad breath?	☐	☐
Are any of your teeth sensitive to hot or cold?	☐	☐
Do your gums sometimes bleed when brushing?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you have any clicking noises or pain in your jaw joints?	☐	☐
Do you suffer from tension headaches?	☐	☐
Do you suffer from dry mouth?	☐	☐
Do you have crowns with black edges?	☐	☐
Do you play contact sports?	☐	☐
Do you now or have you ever taken steroids?	☐	☐
Are your dentures loose or ill-fitting?	☐	☐
Are you unhappy with the appearance of any fillings?	☐	☐
Do you feel your teeth are stained?	☐	☐
Do you have any missing teeth?	☐	☐
If yes, would you like the gaps filled?	☐	☐
Are you satisfied with the appearance of your teeth?	☐	☐
Would you like a brighter smile?	☐	☐
Would you like straighter teeth?	☐	☐
Is there anything else about your teeth you'd like to discuss?	☐	☐

If yes, please give details ....

Are you in any private medical scheme that allows full/part refund of dental charges? If yes, please give details ....

Completed by: Self ☐ Parent ☐ Guardian ☐

Signature

Date